

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 3 - 0 1 7b

DATE:

Michigan

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

April 1, 2003

10/1/03

per state
letter
3/31/04

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447

7. FEDERAL BUDGET IMPACT:

a. FFY 04 \$ -8,000,000
b. FFY 05 \$ -10,000,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Supplement to Attachment 3.1-A, pg 24.1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Supplement to Attachment
3.1-A, pg 24.1

10. SUBJECT OF AMENDMENT:

Pharmacy Supplemental Rebate Agreements

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:

Paul Reinhart, Director

Medical Services Administration

12. SIGNATURE OF STATE AGENCY OFFICIAL:

Paul Reinhart

13. TYPED NAME:

Paul Reinhart

14. TITLE:

Director - Medical Services Administration

15. DATE SUBMITTED:

12-5-03

16. RETURN TO:

Medical Services Administration
Program Policy-Federal Liaison Unit
400 South Pine - 7th Floor
Lansing, Michigan 48933
ATTN: Nancy Bishop

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

12-8-03

18. DATE APPROVED:

4/22/04

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

10/01/03

20. SIGNATURE OF REGIONAL OFFICIAL:

Cheryl A. Harris

21. TYPED NAME:

Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid

23. REMARKS:

Children's Health

MAR 15 2004

DMCH - ARA

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MICHIGAN

***Amount, Duration and Scope of Medical and Remedial Care
Services Provided to the Categorically and Medically Needy***

12. Drug Products, Dentures, Prosthetic and Orthodic Devices, Eyeglasses (continued)

a. Drug Products (continued)

7. A drug use review program, including prospective and retrospective drug utilization review, has been implemented in compliance with federal law.
8. Claims management is electronic, in compliance with federal law.
9. The state is in compliance with Section 1927 of the Social Security Act. Based on the requirements for Section 1927 of the Act, the state has the following policies for the supplemental rebate program for the Medicaid population:
 - (A) A rebate agreement between the state and a drug manufacturer for drugs provided to the Medicaid population, submitted to CMS on January 15, 2002 and entitled "State of Michigan Supplemental Drug Rebate Agreement" has been approved by CMS. Additional supplemental rebate agreements submitted on December 8, 2003 have been authorized by CMS. CMS has approved the State of Michigan to enter into the Michigan multi-state pooling agreement (MMSPA).
 - (B) Supplemental rebates received by the State in excess of those required under the national drug rebate agreement will be shared with the Federal government on the same percentage basis as applied under the national drug rebate agreement.
 - (C) All drugs covered by the program, irrespective of a prior authorization requirement, will comply with provisions of the national drug rebate agreement.

b. Dentures

Dentures are a covered benefit for recipients under the EPSDT program if determined necessary by a licensed dentist (Item 10 of this attachment) to correct masticatory deficiencies likely to impair general health. Prior authorization is required. If the client has an existing denture, replacement is permissible only if the existing denture cannot be relined or rebased, whether or not the existing denture was obtained through the Michigan Medical Assistance Program.

Reimbursement for complete or partial dentures includes the costs of any necessary adjustments within six months of insertion. Dentures will be replaced when medically necessary. Prior authorization is required.

c. Prosthetic and Orthotic Devices

Such devices are provided under the following conditions only:

1. when provided to a hospital inpatient, upon a physician's order indicating that the device is essential to the client's medical treatment plan; or,
2. when prior authorized as medically necessary and provided on an outpatient basis or for a recipient in a long term care facility.

TN NO. 03-17b

Approval Date APR 22 2004

Effective Date 10/01/03

Supersedes

Dental Effective 10/01/03

TN No. 03-11